

Department of Veterans Affairs Community Living Center Survey Report

This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

General Information:

Location: Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)

Dates of Survey: 12/3/2019 to 12/5/2019

Total Available Beds: 240

Census on First Day of Survey: 210

F-Tag	Findings
F550	<p>Based on observation, interview and record review, the CLC did not treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of the resident's quality of life. Findings include:</p> <p><u>Resident #409, [LOCATION]</u></p> <ul style="list-style-type: none"> Resident #409 was admitted to the CLC on [DATE] following hospitalization. The resident's diagnoses included schizoaffective disorder and traumatic brain injury. The resident participated in the STAR-VA program. A STAR-VA ABC assessment plan of care dated 12/03/19 indicated Resident #409 was "constantly asking for pudding....Activators: Has difficulty communicating his needs....environment – noisy, crowded dayroom [living room]...." The nursing station in the [LOCATION] neighborhood was secured. It had a counter at wheelchair height with an opening with a metal doorlike partition that could be opened and closed. On 12/03/19 at approximately 1:55 p.m., Resident #409 was observed walking with a rolling walker in the living room in the [LOCATION] neighborhood. The resident was observed to approach the nursing station and request something to eat. Staff, including the nurse manager, a nursing assistant, and two registered nurses, were present in the nursing station and could see and hear the resident (the steel door was raised). Staff in the nursing station did not acknowledge the resident or offer the resident something to eat. On 12/05/19 at 9:25 a.m., Resident #409 was observed standing with a walker near the opening to the nursing station asking for chocolate pudding; a nursing assistant and an RN were observed inside the secured nursing station. The staff were not interacting with Resident #409 and did not respond to the resident's request for pudding. The surveyor entered the nursing station to ask the RN a question about another resident; the surveyor did not use the other resident's name. The nurse manager instructed the nursing assistant to "close the gate [meaning close the opening between the staff and Resident #409]." The NA was observed to stand up and abruptly close the partition without first informing Resident #409. The nurse manager stated, "We have to close it for confidentiality." Following the observation, Resident #409 was observed seated in a chair near the nursing station. On 12/05/19 at approximately 11:00 a.m., CLC leadership staff indicated that closing the gate without alerting a resident was not what was expected when there were other options to ensure confidential discussions.

483.10(a)(1)(2)(b)(1)(2) §483.10(a) *Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

F580

483.10(g)(14)(i)-(iv) §483.10(g)(14) *Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is— (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is— (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).*

Level of Harm - No actual harm with potential for more than

Based on observation, interview and record review, the CLC did not immediately consult with the resident's provider when there was a significant change in the resident's physical, mental or psychosocial status. Findings include:

The CLC policy titled, "Responding to Emergency and Non-Emergency Conditions," and dated October 26, 2019, was provided by the deputy chief nurse [DCN] on 12/04/19 at 3:00 p.m. According to the policy, "All patients [residents] with a sudden change in their medical status must be promptly assessed. This assessment must determine first whether they are in cardiac arrest or are likely to have other life-threatening emergencies. It includes a determination of vital signs and other findings as directed by the patient's condition...."

The CLC policy titled, "Interdisciplinary Assessment of Patients," and dated July 7, 2017, was provided by the quality performance specialist on 12/04/19 at 12:55 p.m. According to the policy, "Reassessment (a) Each patient will be reassessed according to the patient's course of treatment to determine the patient's response to treatment, when significant changes occur in the patient's condition, or when a change occurs in the patient's diagnosis."

Resident #203, [LOCATION]

- Resident #203 was admitted to the CLC on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), atrial fibrillation, chronic malnutrition and non-Alzheimer's dementia.
- The quarterly Minimum Data Set (MDS) dated 10/10/19 indicated the resident usually understood and was usually understood by others, had clear speech, and had a Brief Interview for Mental Status (BIMS) score of 3 suggesting severely impaired cognition. According to the MDS, the resident required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene; and received scheduled pain medication.
- During the initial tour on 12/03/19 at approximately 10:55 a.m., the charge nurse indicated that Resident #203, "Has been here a few months and was admitted with combativeness. He likes to sleep in bed most of the time and prefers select female staff. They try and bring him to the dining room to eat. He doesn't have the best appetite, eats 25-50% but is drinking pretty well. He tends to skip meals."
- According to the most recent pain assessment dated 11/09/19, the resident had no reports of pain.
- Vital sign documentation included the following:
 - 09/02/19 – pulse 86 (beats per minute), blood pressure (B/P) 105/57
 - 10/02/19 – pulse 52, B/P 94/65
 - 11/04/19 – pulse 72, B/P 151/75
 - 11/13/19 – pulse 87, B/P 117/77
- Nursing progress notes included the following:
 - 12/01/19, 9:24 p.m.: "Patient alert and to his baseline, refused to eat but drunk [drank] 240cc [cubic centimeters] of fluids. Patient was compliant with his care this shift and given a shower. 15 minute safety checks in place. We continue to monitor."
 - 12/02/19, 1:22 a.m.: "At the start of the shift veteran awake and seated in dayroom under staff supervision Slept in recliner until 0230 [2:30 a.m.] then retired to bed. Safety maintained. Will continue to monitor."
 - 12/02/19, 2:16 p.m., "Veteran up early in dayroom watching tv. Joined recreational staff for activities. Refused eye drops and inhaler despite several attempts. Poor appetite for meals. 15 minute checks maintained for safety. Will continue to monitor."
 - 12/03/19, 1:31 a.m.: "Veteran in bed at the start of the shift, slept well thru the night. No voice complaint [sic]. Continue on 15 minute safety checks, safety maintained. Will monitor."
- On 12/03/19 at 2:40 p.m., Resident #203 was observed lying in bed in his room; the DCN introduced the resident to the surveyor and then left the room. The surveyor went to the side of the resident's bed and asked how the resident was feeling. The resident put both hands to his chest and said, "My chest hurts." The surveyor asked if the resident reported the chest pain to the nursing staff and the resident waved his hands

minimal harm that is not
immediate jeopardy

Residents Affected - Few

back and forth and said, "They just come and go out of here so fast." When the surveyor asked the resident if the nurse could be notified by the surveyor, the resident stated, "Yes." The surveyor went into the hallway and told the DCN that the resident was complaining that his chest hurt. The DCN notified an LPN who came to the resident's room with the vital sign machine. The surveyor told the LPN that the resident complained of his chest hurting. The LPN asked the resident where he was hurting and the resident put his hands between his chest and his stomach. The DCN and surveyor left the room as the LPN took the resident's vital signs.

- Documentation indicated the resident's vital signs were taken on 12/03/19 at 2:45 p.m. and recorded as follows: pulse 110, respirations 18 (breaths per minute), B/P 88/62. The provider was not notified regarding the resident's complaints of chest and/or abdominal pain, the blood pressure of 88/62 or the elevated (compared to the resident's baseline) pulse rate of 110.
- According to the nursing progress note dated 12/03/19 at 3:50 p.m., "Veteran [resident] in bed the whole shift. Agreed to ADLs [activities of daily living] after much encouragement. Refused medications despite several attempts. Also refused meals. In the afternoon c/o [complained of] stomach pain. VS [vital signs] taken and documented in CPRS [computerized patient record system]. Fluids and snack offered. Only agreed to have some sips of his drink. Charge nurse notified. Veteran continues on 15 minute checks for safety. Will continue to monitor."
- The daily shift report dated 12/03/19 indicated Resident #203 was "FULL CODE" and documented, "Female Caregivers Only...2 staff assist [provide assistance] at all times. Continues on 15 minute safety checks, sleeping in bed at start of shift. Slept well. Continue on 15 minute safety checks. Cooperative with care. c/o [complaints of] belly pain. Ginger ale given with fair effect."
- No further resident assessment was documented and vital signs were not recorded until 7:30 p.m.
- According to a nursing long-term care note dated 12/03/19 at 8:07 p.m., "At approximately 7:30 p.m., the med [medication] nurse walked in the veteran's room and observed the veteran lying on the bed on his right side, incontinent of bowel. Nurse called for help and 2 nursing staff came and assisted. Veteran ambulated to the bathroom via [using] contact guard [assistance] with R/W [rolling walker]. When ambulating, veteran became weak, knees buckled, staff lowered veteran to the floor safely and [the resident] became unresponsive for approximately 1 min [minute]. At this point veteran's BP taken 119/59 pulse 148. Charge nurse notified MOD [medical officer of the day] on the incident. MOD requested VS repeated."
- The MOD note dated 12/03/19 at 8:45 p.m. stated, "Pt. [patient] noted to be tachycardic to 140s with BP of 120/70 [no blood pressure of 120/70 was recorded in the vital sign record, the documented blood pressure was 119/59]. I requested a repeat set of vitals, IV [intravenous access] and BS [blood sugar] check and was going to see pt. Shortly thereafter a rapid response was called. On arrival, CPR [cardiopulmonary resuscitation] was in progress...." The resident subsequently passed away at the hospital. The DCN stated that the resident's death was not expected.
- On 12/04/19 at 12:50 p.m., the DCN was interviewed regarding the lack of reassessment following Resident #203's complaints of chest/belly pain, low blood pressure and increased heart rate. The DCN stated, "I would have expected a repeat of the vitals. The LPN believed [the resident] was dehydrated and offered ginger ale." When asked if a pain assessment should have been conducted, the DCN said, "Yes, I would have expected that."
- On 12/05/19 at 9:00 a.m., the charge RN on duty during the day shift on 12/04/19 was interviewed by telephone. The RN said that he was told by the LPN that Resident #203, "Pointed to his chest area, then belly saying there was pain, the blood pressure was low and heart rate high. She [the LPN] gave ginger ale." The RN said he checked on Resident #203 and the resident was resting. The RN stated, "I went later to take vitals [time not specified], but he refused stating he felt better. I was going to do a quick note in CPRS but didn't get to it. I did communicate to oncoming [staff] that vitals seemed off." The LPN or RN did not notify the medical provider of the resident's complaints of pain or the resident's vital signs.
- The DCN indicated following the telephone interview with the RN that the resident refused care from male caregivers and that female caregivers were preferred suggesting that the reason the resident refused to have the vital signs taken was because the RN was male.
- On 12/04/19 at 4:15 p.m., the charge RN on duty during the evening shift on 12/04/19 was interviewed. The RN said that when she came on duty around 4:00 p.m. on 12/04/19, "He [Resident #203] was in bed and looked comfortable so I didn't wake him." I received report and the day shift charge RN said that Resident #203 "complained of a stomachache and discomfort in his chest. I had two other residents that I saw before going to see [Resident #203]. He opened his eyes and I asked if anything hurt and he said, no. I palpated his belly and nothing. I assessed his belly with the stethoscope and noted nothing. His heart rate was 58. I didn't do other vitals. My understanding was that

[charge RN from day shift] had assessed him.” When asked if the resident had complained of belly or chest pain prior to 12/03/19, the RN said, “No, sometimes he says his belly is full but no pain.” The RN said she did not document a note of the events leading up to the unresponsive incident but was going to document a late entry.

- In summary, on 12/03/19 at 2:40 p.m., Resident #203 complained of chest and/or belly pain; the resident’s blood pressure was 88/62 and the resident’s pulse rate was elevated (110) compared to the resident’s baseline. The nursing progress note dated 12/03/19 at 3:50 p.m. documented the resident remained in bed the entire shift and refused meals and medications. The provider was not notified regarding the resident’s complaints of pain or vital signs. No additional assessment of the resident was documented and no vital signs were recorded until approximately 7:30 p.m. when the resident became unresponsive. At that time, the MOD was notified. The MOD note dated 12/03/19 at 8:45 p.m. stated, “Pt. [patient] noted to be tachycardic to 140s with BP of 120/70 [no blood pressure of 120/70 was recorded in the vital sign record, the documented blood pressure was 119/59]. I requested a repeat set of vitals, IV [intravenous access] and BS [blood sugar] check and was going to see pt. Shortly thereafter a rapid response was called. On arrival, CPR [cardiopulmonary resuscitation] was in progress....” The resident subsequently passed away at the hospital. The DCN stated that the resident’s death was not expected.

F584

483.10(i)(1)-(7) §483.10(i) *Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide—* §483.10(i)(1) *A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

Based on observation, interview and record review, the CLC did not provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior. Findings include:

[LOCATION] Neighborhood

- On 12/03/19 at approximately 1:50 p.m. after entering the [LOCATION] neighborhood, an odor of urine was noted near [LOCATION] and the adjacent [LOCATION]. The odor was pervasive and noted during all three days of the survey. While walking in the hallway near [LOCATION] and the [LOCATION], the floor surfaces were sticky. On 12/04/19 at approximately 9:30 a.m., the [LOCATION] neighborhood nurse manager was asked to walk toward [LOCATION] and the [LOCATION]. The nurse manager stated the odors had been noted for “six months” due to residents urinating on the floors. The nurse manager indicated that when residents urinated in the [LOCATION] room, the urine puddled and “runs under the cabinets [wardrobes]...there’s nothing we can do...they [the wardrobes] have to be moved.” An RN was observed passing medications in the [LOCATION] room; the RN stated, when a resident “voids on the floor and in the grill [wall mounted radiator]...you can’t clean it....” An environmental management services (EMS) staff person was observed cleaning the floor in the [LOCATION] neighborhood near the community bathroom entrance, and was interviewed at approximately 9:35 a.m. The EMS staff member was asked about the urine odor and he stated, “It’s been this way...not sure how long...I told my supervisor.” The EMS staff member acknowledged that he was unable to clean under the wardrobes in the [LOCATION] room as they were mounted to the floor, and indicated he was unable to clean the wall-mounted heating grates. (See Dementia Treatment and Services)

[LOCATION] Neighborhood

- During observations of Resident #104’s private room on 12/04/19, there was damaged drywall behind the headboard of the resident’s bed. The wall was noted to have several one to two-foot long vertical gouges in the drywall extending above the head of the bed; damage appeared to be from the bed moving against the wall. The damaged wall was visible from the hallway.

[LOCATION] Neighborhood

- On 12/03/19 at 2:05 p.m. and 12/04/19 at 9:08 a.m., the floor in Resident #102’s room was visibly soiled with what appeared to be a dried spill. The dried spill was dark gray and covered an area approximately three feet by three feet. A dried shoe print was visible on the floor. A glove was observed behind the head of Resident #102’s bed and an accumulation of dust was observed behind the head of the bed and on the nightstand.

[LOCATION] Neighborhood:

- On 12/03/19 at approximately 1:40 p.m., the floor near the dining room in the [LOCATION] neighborhood was observed to be sticky. The same floor surfaces were noted to be sticky during observations at 2:40 p.m. on 12/03/19.

F686

483.25(b)(1)(i)(ii) §483.25(b) *Skin Integrity. §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that— (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure residents received care consistent with professional standards of practice to prevent pressure ulcers. Findings include:

Resident #102, [LOCATION]

- Resident #102 was admitted to the CLC on [DATE]. Resident #102's most recent quarterly MDS dated 08/09/19 indicated the resident was totally dependent on two staff for bed mobility. According to the MDS, the resident did not have pressure ulcers; skin and ulcer treatments coded on the MDS included pressure reducing devices for a bed and chair, a turning and repositioning program and application of ointments/medications other than to the feet. The Care Area Assessment (CAA) summary dated 06/24/19 and completed in conjunction with the comprehensive assessment dated 06/08/19 indicated the resident's Braden Scale for Predicting Pressure Ulcer Risk score was 13 suggesting moderate risk for pressure ulcers. Resident #102 had a Stage 1 pressure ulcer on the buttocks; the Stage 1 pressure ulcer was healed at the time of the survey.
- The plan of care dated 08/18/19 read, "Please ensure I am wearing heel lift boots to protect my left heel and I am wearing Prevalon boots for protection of my right heel."
- On 12/03/19 from 1:59 p.m. to 2:21 p.m., the following was observed. Resident #102 was transferred into bed from his wheelchair. Once the resident was positioned in bed, his shoes were removed, and both heels were placed directly on the mattress; the resident's heels were not elevated and protective boots were not applied. Upon observation, the resident's feet were free of open areas or skin breakdown.
- During observation of resident care on 12/04/19 at 9:08 a.m., two foam boots were observed in the resident's room on the personal care cart. When asked about the boots, the assistant RN manager stated that Resident #102 was to wear the boots when in bed to protect his heels from skin breakdown. Upon completion of the care observation, the protective boots were not placed on the resident's feet and the resident's heels rested directly on the mattress.

F688

483.25(c)(1)-(3) §483.25(c) *Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that a resident with a limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. Findings include:

Resident #404, [LOCATION]

- Resident #404 was admitted to the CLC on [DATE] with diagnoses including Lewy body dementia and Parkinson's disease. The history and physical dated 03/27/19 indicated the resident had "no muscle, back pain, joint pain, or stiffness."
- The comprehensive MDS dated 05/15/19 indicated Resident #404 had moderately impaired cognitive skills for daily decision making based on staff assessment; the resident did not have behavioral symptoms or reject care. According to the MDS, the resident was dependent upon staff for bed mobility and transfers and had functional limitations in range of motion in the bilateral upper and lower extremities; the resident had no indicators of pain or possible pain based on staff assessment. The most recent quarterly MDS dated 10/17/19 was coded similarly except the resident had functional limitations in range of motion in the bilateral upper extremities and no limitations in the lower extremities.
- A provider's current order dated 09/01/17 stated, "Bilateral hand splints for positioning and comfort. Apply after morning care. Increase wearing time as tolerated by one hour per day up to 4 hours. If pressure areas or discomfort noted, discontinue use and notify OT [occupational therapy]."
- A "restorative nursing" plan dated 10/24/19 identified a goal for "active and passive ROM [range of motion] to BUE [bilateral upper extremities]." The restorative nursing plan did not address the use of hand splints to prevent further contractures.
- The most recent interdisciplinary team care plan dated 12/01/19 did not address the use of bilateral hand splints.
- On 12/03/19 at approximately 10:25 a.m. during the initial tour, Resident #404 was observed seated in a wheelchair in the living room in the [LOCATION] neighborhood; the resident was observed to have bilateral hand contractures with the resident's fingers curled into fists. The resident had no splints or other devices in place in either hand. Each of the resident's hands had closed fingers against the palms while the thumbs extended away from the palm of the hands. On 12/03/19 at 1:40 p.m. and 2:40 p.m., Resident #404 was again observed seated in a wheelchair in the living room; the resident was not wearing hand splints in either hand. During the observation at 2:40 p.m., an LPN approached the resident and provided range of motion to the resident's

hands and upper arms. When asked if the resident used hand splints, the LPN stated that after the splints were applied, "He [Resident #404] will sometimes push them off." There was no evidence of the hand splints in the resident's lap or near the resident during each of the above noted observations.

- On 12/04/19 at approximately 9:03 a.m., Resident #404 was observed seated in his wheelchair in the living room with hand splints in both hands.

F689

Based on observations, interviews and record review, the CLC did not ensure that each resident received supervision to prevent accidents. Findings include:

483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that – §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Resident #202, [LOCATION]

- Resident #202 was admitted to the CLC on [DATE] with diagnosis including Alzheimer's disease. The resident's comprehensive MDS dated 09/26/19 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The resident required total assistance for all activities of daily living (ADLs) including eating; no signs or symptoms of a swallowing disorder were identified.
- The provider orders dated 03/17/15 indicated, "Regular diet."
- The history and physical dated 12/04/19 stated, "He had a SLP [speech language pathology] consult for swallowing evaluation."
- A speech language pathology consult dated 07/01/19 stated, "Swallow Evaluation: RN reports cough after eating/drinking." According to the 07/01/19 speech pathology consult, "Aspiration risk is judged INCREASED [emphasis not added] for this individual, especially during times of lethargy, somnolence or fatigue, such as at end of meal. STRICT ASPIRATION PRECAUTIONS [emphasis not added] are warranted....Supervision level 1:1 [one-to-one] feeding assist [assistance] with strict use of compensatory strategies below: ALTERNATE SIPS OF LIQUIDS, BITES OF FOOD [emphasis not added]...."
- The care plan dated 07/13/19 identified a concern related to nutrition. Approaches stated, "Nursing to feed at meals. Follow SLP recommendations. Maintain ASPIRATION PRECAUTIONS [emphasis not added]." The care plan did not indicate that compensatory strategies were to be used including alternating sips of liquid with bites of food.
- According to the nutrition quarterly assessment dated 10/01/19, "Nutrition Prescription: REGULAR diet order. SLP consult, prn [as needed]. Nursing to feed at meals. [Resident's spouse] typically feeds Veteran at lunch or dinner when she visits. Follow SLP recommendations. Maintain ASPIRATION PRECAUTIONS [emphasis not added]...."
- The most recent monthly nursing note dated 10/09/19 (signed as completed on 12/04/19) indicated the resident had "increased coughing at meals."
- On 12/04/19 at 8:10 a.m., a nursing assistant (NA) was observed assisting Resident #202 with the breakfast meal. The deputy chief nurse (DCN) and nurse manager (NM) were present during the observation. The resident was in bed and the NA raised the head of the resident's bed to 90 degrees. The NA fed the resident a bowl of oatmeal, allowing time between the bites, but did not alternate bites of food with liquid. After the resident finished eating the oatmeal, the resident drank a cup of juice as offered by the NA using small sips. The NA cut a piece of French toast into bite-sized pieces and fed the resident four forkfuls (2 bite-sized pieces at a time) before offering a sip of juice. After a sip of juice, the NA repeated with three forkfuls of French toast (2 bite-sized pieces at a time) before offering another sip of juice. When the resident finished eating the French toast, the NA cut a cup of fresh fruit (strawberries and blueberries) into bite-sized pieces. The NA fed the resident the cup of fruit without offering liquids. When the resident finished eating the fruit, the resident had two sips of juice at which time he coughed slightly but was able to clear his throat. The resident then finished the cup of juice.
- On 12/05/19 at 12:35 p.m. during an interview, the speech pathologist stated that she had not seen the resident since the July 2019 consult but had reviewed the resident's medical record. The speech pathologist said that the "nurses are aware that they are not to give him all the solids at one time" and unless the consult indicated "strict use" of alternating bites and liquids, it "would be ok to offer liquids after every few bites or so." As indicated in the 07/01/19 consult, the speech pathologist recommended, "1:1 feeding assist [assistance] with strict use of compensatory strategies below: ALTERNATE SIPS OF LIQUIDS, BITES OF FOOD [emphasis not added]...."
- On 12/04/19, the DCN indicated that the CLC did not have a policy related to aspiration

or swallowing precautions. The DCN stated NAs could carry a laminated card as a reference guide. The laminated card outlined aspiration precautions, choking risk precautions, meal time energy conservation precautions, and reflux precautions. The aspiration precautions portion of the card stated, "HOB [head of bed] elevated/seated 90 degrees (HIGH Fowler's) when eating and drinking, staff observe/feed patient if needed, HOB > [greater than] 30 degrees at all times. Ensure thorough ORAL CARE [emphasis not added], at least every shift to reduce aspiration pneumonia risk (secretions), D/C [discontinue] any p.o. [oral] trial if recurrent coughing, increased secretions, increased RR [respiratory rate], sat [oxygen saturation] < [less than] 90% observed." The laminated card did not include resident specific strategies to be used as specified by the speech pathologist.

F744

483.40(b)(3) §483.40(b)(3) *A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

Based on observation, interview and record review, the CLC did not ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Findings include:

[LOCATION]

On 12/03/19 at approximately 2:20 p.m., the [LOCATION] neighborhood was observed to have a centrally located community (neighborhood) bathroom.

Resident #406

- Resident #406 was admitted to the CLC on [DATE] with diagnoses including dementia and chronic obstructive pulmonary disease (COPD). The resident's comprehensive MDS dated 11/21/19 indicated Resident #406 had a Brief Interview for Mental Status (BIMS) score of 8 suggesting moderately impaired cognition; the resident had signs and symptoms of delirium including disorganized thinking and inattention that fluctuated, verbal behavioral symptoms directed toward others and rejected care four to six days during the review period. According to the MDS, the resident required supervision with transfers, used a walker for mobility, ambulated in the corridor with supervision, and was frequently incontinent of urine; the resident was not on a toileting program.
- The interdisciplinary team care plan included a statement dated 11/24/19 that read, "Integumentary....I want my skin to stay dry, I will ask to change my clothes when wet...." The care plan did not indicate the resident used a urinal or was expected to empty his urine collection device in the neighborhood bathroom.
- Nursing LTC (long term care) notes indicated the following:
 - 11/16/19 – "...strong odor in room noted, veteran declining personal hygiene/care x 3 [three times] attempts by different staff members...continent of urine, utilizes urinal at bedside."
 - 11/17/19 – "Educated veteran to discard urine after voiding and not to leave urinal on his table."
 - 11/18/19 – "Incontinent of large amount of urine, declined shower...."
 - 11/21/19 – "Continued to be reclusive to his room and using urinal instead of toilet."
- A physical therapy note dated 12/02/19 indicated, "LTG [long term goal]: sit/stand RW [rolling walker] form [sic] bed and facility chairs...."
- On 12/03/19 at approximately 1:50 p.m. during an interview with Resident #406 in the resident's room ([LOCATION]), it was difficult to maintain a conversation because of the odor of urine. The clinical resource RN was present during the observation and acknowledged the same odor. A urine collection device was observed on top of the resident's overbed table and contained approximately 50 milliliters of urine. It was noted while walking in the hallway near the resident's room and the [LOCATION] room, the floor surfaces were sticky.
- On 12/05/19 at approximately 9:00 a.m., the resident's room continued to have a strong urine odor. An empty urine collection device (urinal) was observed on the resident's overbed table. The resident was asked how the urine collection device was emptied and the resident responded, "They [staff] empty it for me." A walker was observed near the resident's bed; the resident indicated that therapy had instructed him to use the walker since his "left hip hurt" when he ambulated.
- On 12/05/19 at 9:10 a.m., the charge nurse indicated that Resident #406 did not require the walker for ambulation and was expected to "empty the urinal on his own." The surveyor asked how the resident would transport the urine collection device while using the walker and the charge nurse stated, "He doesn't need the walker...we tell him to use the toilet, he refuses...uses the urinal...he spills it on the floor in his room [suggesting this caused urine odors in the resident's room]." The charge nurse

acknowledged that the community bathroom was not located near the resident's bedroom. The surveyor estimated the distance between the resident's room and the community bathroom where the resident was supposed to empty the urine collection device was approximately 20 feet. The clinical resource nurse who accompanied the surveyor was present during the interview.

Resident #407

- Resident #407 was admitted to the CLC on [DATE] with diagnoses that included frontotemporal dementia and agoraphobia (anxiety disorder with a fear of places and situations that might cause panic, helplessness or embarrassment). The resident's comprehensive MDS dated 11/05/19 indicated the resident had severely impaired cognitive skills for daily decision making based on staff assessment; the resident had signs and symptoms of delirium that included continuous inattention and disorganized thinking; rejected care four to six days during the review period; did not have verbal or physical behavioral symptoms or indicators of psychosis; and experienced wandering daily that significantly intruded on the privacy or activities of others. According to the MDS, the resident was able to ambulate in the corridors and use the toilet with supervision, and was occasionally incontinent of urine and bowel.
- The resident's interdisciplinary care plan included a problem dated 10/31/19 that read, "ADL [activities of daily living] functional rehabilitation potential: Resident is depended upon others for ADL assistance and has unmet needs, feelings of helplessness, isolation and loss of control." An approach stated, "Assist and/or encourage with bathing, dressing and grooming." The care plan did not address the resident's urinary and bowel incontinence or agoraphobia. The diagnosis of agoraphobia had not been considered a potential contributing factor to the resident's incontinence.
- The resident's STAR-VA ABC assessment dated 12/02/19 completed by a psychiatrist indicated, "Behavior: defecating in inappropriate places (radiator, drawers, closets)...in different rooms on the unit [neighborhood]...since he was admitted to the [LOCATION] most recently on 10/30/19....Context of behavior: frontotemporal dementia...characterized by socially inappropriate behavior and disinhibition. Consequences: staff redirect the veteran to the bathroom, use pull-ups [briefs], communicate with him about using the bathroom for bowel movements...tried giving the veteran his own room but he kept wandering back to his old [LOCATION] room...staff have not yet tried using a commode and will now try...only community bathrooms are available on this unit, but one staff member mentioned that veteran was using bathroom more consistently when he had personal bath [room] on another unit [neighborhood]."
- During medication administration observations on 12/03/19 at approximately 2:25 p.m., Resident #407 was lying in bed with blankets covering his head. A commode was not visible in the resident's room.
- On 12/04/19 at approximately 9:30 a.m., an RN who was passing medications for Resident #407 stated, "He [Resident #407] voids on the floor and in the grill [wall mounted radiator]...you can't clean it....We are going to try a bedside commode to see if he'll use it." The RN did not indicate why the bedside commode had not been implemented since it was addressed in the 12/02/19 STAR-VA assessment.

Resident #408

- Resident #408 was admitted to the CLC on [DATE] with diagnoses that included dementia with behavioral disturbances. The most recent quarterly MDS dated 10/23/19 indicated the resident had moderately impaired cognitive skills for daily decision making based on staff assessment; the resident had signs and symptoms of delirium that included continuous inattention and an altered levels of consciousness, had physical behavioral symptoms directed toward others, rejected care, and wandered one to three days during the review period. According to the MDS, the resident was able to ambulate in the corridors with supervision and was always incontinent of urine and bowel.
- A STAR-VA ABC assessment dated 08/21/19 written by a psychologist indicated, "Urinating and defecating on the floor...urinates on the bedding...Veteran will sometimes allow staff to take him to the bathroom, when he reaches the bathroom, he may become combative....The Veteran will often be in bed right before the behavior happens. He wears adult diapers but this doesn't help. At this point, staff doesn't regularly cue the Veteran to use the bathroom, and they become alarmed when his mood shifts rapidly (from agreeing to go to the toilet, to being aggressive when they reach the toilet)." The note further indicated, "Nursing staff will cue the Veteran every 1-2 hours to use the bathroom...Educated staff that he may be getting combative by the time he reaches the bathroom because he forgets where he is...."
- The interdisciplinary team care plan dated 09/29/19 included a statement that read, "Behavior symptoms...confused night and day related to psychiatric diagnoses of dementia. Establish rising and bedtime schedule....Explain all procedures...schedule to distinguish between day and night. Notify physician and family of any changes in status." The care plan did not address urinary or bowel incontinence or reference the recommendations in the STAR-VA plan.

Systems-level Review

- On 12/03/19 at approximately 1:50 p.m. after entering the [LOCATION] neighborhood, an odor of urine was noted near [LOCATION] and the [LOCATION] room. The odor was pervasive and noted during all three days of the survey. While walking in the hallway near [LOCATION] and the [LOCATION] room, the floor surfaces were sticky. On 12/04/19 at approximately 9:30 a.m., the [LOCATION] neighborhood nurse manager was asked to walk toward [LOCATION] and the [LOCATION] room. The nurse manager stated the odors had been noted for “six months” due to residents urinating on the floors. The nurse manager indicated that when residents urinated in the [LOCATION] room, the urine puddled and “runs under the cabinets [wardrobes]...there’s nothing we can do...they [the wardrobes] have to be moved.” An RN was observed passing medications in the [LOCATION] room; the RN stated, when a resident “voids on the floor and in the grill [wall mounted radiator]...you can’t clean it....” An environmental management services (EMS) staff person was observed cleaning the floor in the [LOCATION] neighborhood near the community bathroom entrance, and was interviewed at approximately 9:35 a.m. The EMS staff member was asked about the urine odor and he stated, “It’s been this way...not sure how long...I told my supervisor.” The EMS staff member acknowledged that he was unable to clean under the wardrobes in the [LOCATION] room as they were mounted to the floor, and he was unable to clean the wall-mounted heating grates.
- During observation, interview and record review it was determined that the CLC did not implement approaches addressing the toileting needs of residents with dementia experiencing urinary and/or bowel incontinence and/or behavioral symptoms that contributed to the pervasive odors in the neighborhood.

F761

Based on observation and staff interview, the CLC did not store all drugs in locked compartments. Findings include:

Resident #306, [LOCATION]

483.45(g)(h)(1)(2) §483.45(g) *Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.* §483.45(h) *Storage of Drugs and Biologicals* §483.45(h)(1) *In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.* §483.45(h)(2) *The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.*

- During medication pass observations on 12/03/19 at 4:25 p.m., an RN retrieved Resident #306’s medications and placed them on top of the medication cart. The RN removed a bottle of brimonidine eye drops from a plastic zip-locked bag and left the plastic bag containing a bottle of bimatoprost eye drops unattended on the top of the medication cart. At 4:31 p.m., the RN went into Resident #306’s room, pulled the privacy curtain and turned toward Resident #306, with the RN’s back to the medication cart; the medication on top of the medication cart was out of the RN’s line of sight. The RN administered the resident’s medication. Although no visitors or other residents were observed near the medication cart, the bottle of bimatoprost eye drops was unsecured and unattended until the RN returned to the medication cart at 4:34 p.m. The deputy nurse executive (DNE) was standing near the medication cart during the observation, observing the medication pass. When the RN returned to the medication cart at 4:34 p.m., the surveyor inquired about the eye drops that were left on top of the medication cart. The RN stated, “Oh, we aren’t using them anymore. They were discontinued.” The DNE nodded in acknowledgement that the drops were left unattended on the top of the medication cart.

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

F880

483.80(a)(1)(2)(4)(e)(f) §483.80
Infection Control. The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

Level of Harm - No actual harm

The CLC did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. Findings include:

Transmission-based Precautions

On 12/04/19 at 11:15 a.m., the clinical resource nurse provided a policy titled, "Transmission-Based Isolation Precautions," with a last revision date of 04/04/19. The policy stated, "Enhanced Barrier Isolation are the Community Living Center's version of Contact Precautions but for MRSA [methicillin-resistant *Staphylococcus aureus*] colonized Veterans. Enhanced Barrier Isolation is designed to reduce the risk of transmission of pathogens that may be spread by direct or indirect contact with the resident or the resident's environment....(b) Requirements for Enhanced Barrier Isolation: 1. Refer to Contact Isolation. The practice is the same." The policy for Contact Isolation stated, "1. Contact Isolation...(c) 2. Patient care items (e.g., blood pressure cuff, stethoscope, thermometer) are to be dedicated to the individual patient and remain in the patient's room."

Linen Handling

On 12/4/19 at 3:55 p.m., the director of quality RN provided the Elsevier's clinical skills quick sheet titled, "Bed Making-unoccupied," and dated 12/04/19. The director of quality RN stated that this was the standard the VA used for employee performance. The Elsevier's quick sheet stated, "Alert: Do not shake used linen or carry it for any length of time, as doing so increases the risk of disseminating microorganisms into the air or onto clothing." Step 13 of the quick sheet indicated, "Remove soiled linen by folding it into a bundle or square, holding it away from the body, and placing it in the linen bag. Avoid shaking or fanning it."

Resident #401, [LOCATION]

- Resident #401 was admitted on [DATE]. An RN indicated during the initial tour on 12/03/19 that Enhanced Barrier Precautions were to be implemented for the resident due to MRSA in the nares. A sign posted near the entrance to the resident's room indicated EBP were to be implemented; staff were to conduct hand hygiene prior to entering the resident's room and don gloves and a gown.
- On 12/04/19 at approximately 8:30 a.m., an LPN was observed administering medication for Resident #401. The LPN conducted hand hygiene and donned gloves and a gown prior to entering the resident's room. During the medication observation, the LPN retrieved a topical medication from a locked wall mounted cabinet in the resident's room. Upon entry to the resident's room, a bottle labeled Biotene® was observed on the resident's overbed table, located next to the resident's bed. A provider's order dated 12/04/19 indicated, "Artificial saliva, liquid [Biotene]" was to be used daily and as needed. After the LPN administered the resident's medications, the LPN picked up the bottle of Biotene using gloved hands and placed the bottle directly on top of the medication cart, located near the doorway to the resident's room, without first placing a barrier; the LPN then placed the bottle inside a drawer in the medication cart. After the LPN doffed the gown and gloves and conducted hand hygiene, the LPN was asked why the Biotene was not stored in the locked wall mounted cabinet. The LPN responded that the bottle of Biotene should have been secured in the locked cabinet and not brought out of the resident's room to the medication cart.

Resident #105, [LOCATION]

- Resident #105 had a provider's order dated 06/04/19 that read, "Enhanced Barrier Isolation, place pt. [patient] on enhanced barrier isolation for (+) [positive] MRSA nares." The plan of care for Resident #105 dated 11/14/19 indicated, "MDRO – Multidrug Resistant Organism, Goal: Resident and Family and staff will not spread MRSA infection. 1) Maintain enhanced barrier isolation per policy, and 2) Educate resident/family on hand hygiene per policy."
- A sign was posted near the entrance to the resident's room indicating Enhanced Barrier Isolation was to be implemented. On 12/04/19 at 9:40 a.m., a nursing assistant wearing a gown and gloves was observed in the resident's room making the resident's bed. A large pile of soiled linen was on the floor; the soiled linens were observed to be directly on the floor and not on or in a barrier, such as a plastic bag. No linen hamper was observed in the room.
- Following the observation, the NA asked the RN resource nurse who accompanied the surveyor, to assist in obtaining a linen hamper. The linen hamper was located down the hallway in a neighborhood bathroom. The RN resource nurse brought the linen hamper to the outside of Resident #105's room and the NA picked up the soiled linen from the floor and placed the linen into the soiled linen hamper; there was no sanitization of the floor once the linens were removed. The RN resource nurse asked that the floor of the room be cleaned immediately.
- On 12/04/19 at 9:55 a.m., the surveyor spoke with the NA about the observation. The NA indicated she had not received training on the handling of soiled linen and did not

with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

know she could not place soiled linens on the floor.

- On 12/04/19 at 10:10 a.m., the infection preventionist RN for the VAMC indicated that when staff were to implement Enhanced Barrier Precautions for a resident, there should be a designated soiled linen hamper in the resident's room; the infection preventionist did not know why there was no hamper in Resident #105's room.

Respiratory Equipment

Resident #102, [LOCATION]

- Resident #102's medical record indicated the resident had diagnoses including COPD (chronic obstructive pulmonary disease) and dementia. The resident received albuterol 2.5 mg/3 ml (2.5 milligrams per 3 milliliters) solution inhalation therapy each morning for COPD.
 - During observation of the resident's room on 12/04/19 from 9:08 a.m. to 9:18 a.m., a buildup of floor dust was noted around the head of the resident's bed and nightstand. There were large pieces of drywall removed from the wall; the exposed drywall was in close proximity to the resident's respiratory supplies. A respiratory mask and nebulizer were stored in a wall cabinet next to the resident's bed near the damaged wall. The respiratory mask with an attached nebulizer cup was observed to be uncovered and in the cabinet near other personal grooming supplies. A plastic bag was observed on the floor. The assistant nurse manager who accompanied the surveyor during the observation stated that the plastic bag was to be used to store respiratory supplies and indicated that the mask and nebulizer should not be stored in the cabinet.
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